Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005051	A. BUILDING _____ B. WING _____	07/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA UNIVERSITY HEALTH	1701 N SENATE BLVD INDIANAPOLIS, IN 46206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of one State hospital complaint. Facility Number: 005051 Survey Date: 7-17-2012 Complaint Number: IN00094287 Unsubstantiated; lack of sufficient evidence Surveyor: Deborah Franco, RN Public Health Nurse Surveyor Indiana University Health is in compliance with 410 IAC 15-1.5, Medical staff, 410 IAC 15-1.5-6, Nursing services, and 410 IAC 15-1.5-8 Physical plant, maintenance, and environmental services, Hospital Licensure Rules. QA: claughlin 07/31/12	S 000		